



State of Alaska
Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
P.O. Box 110806
Juneau, Alaska 99811-0806
Telephone: (907) 465-2550 ★ Fax: (907) 465-2974
E-mail: license@alaska.gov
Website: www.commerce.state.ak.us/occ

**APPLICATION FOR EXAMINATION ACCOMMODATIONS
FOR CANDIDATES WITH DISABILITIES**

To request accommodations on an examination administered through the Division of Occupational Licensing, the candidate is to complete the front of the form (page 1). A licensed/certified or otherwise qualified professional whose credentials are appropriate to diagnose, evaluate, and treat the disability is to complete the back of the form (page 2). **The professional must have diagnosed, evaluated, or treated the candidate within the last three years and have current knowledge of the candidate's disability and its impact on major life activities.** Candidates with learning disorders or other mental/psychological disorders must enclose with this form a copy of documentation (*i.e., educational assessment report, psychological report*) which provides diagnostic/clinical data confirming the diagnosis. Persons with learning disabilities must submit results from the psychoeducational assessments given to diagnose. Documentation should be no more than three years old. The candidate and the professional should consult and come to an agreement as to the reasonable and appropriate accommodations recommended on page 2. If information regarding the examination is needed (*i.e., format, time limits, etc.*), contact the division regarding the specific exam you are applying for.

TO BE COMPLETED BY THE CANDIDATE (Please print or type all responses):

I. CANDIDATE INFORMATION:

Full Name: _____
Street Address: _____
City, State, Zip Code, Country: _____
Daytime Telephone No. (*with Area Code*): _____
Examination/License Type for which you have applied: _____
Have you received accommodations on a previous examination administered through the Alaska Division of Occupational Licensing? Yes No

II. CANDIDATE'S DISABILITY (Check all that apply):

- Deaf or hearing impaired
- Blind or vision impaired
- Specific learning disability
- Psychological/psychiatric/mental disorder
- Orthopedic/physical disability
- Other health impairment

III. DISABILITY AND TESTING ACCOMMODATIONS HISTORY:

1. The disability was **diagnosed:** less than one year ago more than two years ago
 one to two years ago
2. In high school, I had an Individualized Educational Program (IEP). Yes No
3. I received testing accommodations for college/graduate school admission tests. Yes No N/A
4. In college/graduate school, I used special services for students with disabilities. Yes No N/A
(If "Yes," submit the Accommodation History Form 08-4449.)

I certify that the information provided by me on this form is true and correct to the best of my knowledge. I authorize the State of Alaska to release the information provided to parties involved in providing the accommodations requested.

SIGN HERE

Candidate's Signature

Date

This form must be completed by a licensed/certified or otherwise qualified professional whose credentials are appropriate to diagnose, evaluate, and treat the disability. **The professional must have diagnosed, evaluated, or treated the candidate within the last three years and have current knowledge of the candidate's disability and the its impact on major life activities.**

CANDIDATE NAME: _____

TO BE COMPLETED BY THE PROFESSIONAL (Please print or type all responses):

I. PROFESSIONAL'S INFORMATION:

Name: _____

Title and Occupation: _____

Address: _____

City, State, Zip Code, Country: _____

Daytime Telephone No. (with Area Code): _____ Fax No. (with Area Code): _____

I am licensed/certified: Yes No Profession: _____

License/Certification Number: _____ State of Licensure: _____

II. DIAGNOSIS AND TREATMENT INFORMATION:

1. **Diagnosis:** _____
(If a specific learning disability or mental/psychiatric disorder, provide the DSM-V diagnosis and code. A COPY OF THE PSYCHOLOGICAL/PSYCHIATRIC OR EDUCATIONAL ASSESSMENT REPORT WITH TEST SCORES MUST BE ENCLOSED.)

2. Describe the manner in which this disability impairs major life activity: _____

3. Last date of your treatment or consultation with the candidate: _____

III. RECOMMENDED ACCOMMODATION(S) FOR CERTIFICATION EXAMINATION:

I have consulted with the candidate as to the accommodation needed. Based on my knowledge of this candidate's disability and current functioning, and in consultation with the candidate, the following accommodations are recommended (**check all that apply**):

- Architecturally accessible test site and accommodation – specify: _____
- Large type for test booklet (if available)
- Reader (with separate room and proctor)
- Writer (to record answers on answer sheet)
- Sign Language Interpreter: for opening instructions only throughout testing period
- Separate room and proctor (not due to use of reader, writer, or sign interpreter)
- Extended time: 25% extra 50% extra 75% extra 100% extra (double)
- Other accommodation(s) – specify: _____

I certify that the information provided by me on this form is true and correct to the best of my knowledge. I authorize the State of Alaska to release the information provided to parties involved in providing the accommodations requested.

SIGN HERE 

Professional's Signature

Date

**This form (with applicable supporting documentation) MUST be mailed by the application deadline to the licensing program for which the candidate is applying:
 Division of Corporations, Business and Professional Licensing
 P.O. Box 110806
 Juneau, Alaska 99811-0806.**



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ACCOMMODATION HISTORY FOR CANDIDATES REQUESTING EXAMINATION ACCOMMODATION

If you have had accommodations granted through educational facilities, Sections I through IV of this form must be completed by professional staff responsible for student services at the institution. This form documents the candidate's history of testing accommodation. You may copy additional forms if more than one institution granted accommodations.

TO BE COMPLETED BY THE CANDIDATE (Please print or type all responses):

CANDIDATE INFORMATION:

Full Name: _____
Street Address: _____
City, State, Zip Code, Country: _____
Daytime Telephone No. (with Area Code): _____
Examination/License Type for which you have applied: _____



**Sections I through IV must be completed by the student disability professional.
(Please print or type all responses.)**

I. STUDENT DISABILITY PROFESSIONAL'S INFORMATION:

Name: _____
Title: _____
Institution: _____
Address: _____
City, State, Zip Code, Country: _____
Daytime Telephone No. (with Area Code): _____ Fax No. (with Area Code): _____

II. CANDIDATE'S DISABILITY STATUS(Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Deaf or hearing impaired | <input type="checkbox"/> Psychological/psychiatric/mental disorder |
| <input type="checkbox"/> Blind or vision impaired | <input type="checkbox"/> Orthopedic/physical disability |
| <input type="checkbox"/> Specific learning disability | <input type="checkbox"/> Other health impairment |

CONFIDENTIAL**CONFIDENTIAL****III. ACCOMMODATIONS PROVIDED TO CANDIDATE IN THE EDUCATION SETTING:**

1. The following accommodations were provided for the candidate while a student at this institution (**check all that apply**):

- Large type for test booklet
- Reader (with separate room and proctor)
- Writer (to record answers)
- Sign Language Interpreter: for opening instructions only throughout testing period
- Separate room and proctor (not due to use of reader or sign interpreter)
- Extended time – specify amount of extended time: _____

Other accommodation(s): Specify – _____

2. Provide the dates (month/year) during which these accommodations were provided: _____

3. Testing accommodations were arranged for the student and monitored by:

- Office of Student and Disability Services
- Institution's Classroom Faculty
- Other: _____

IV. DOCUMENTATION OF THE DISABILITY:

This institution or the disabilities services office has on file (or had on file at the time of accommodations) documentation/diagnostic data confirming the candidate's disability. Yes No

I certify that the information provided by me on this form is true and correct to the best of my knowledge. I authorize the State of Alaska to release the information provided to parties involved in providing the accommodations requested.

SIGN HERE _____
Signature of Student Disability Services Office Staff_____
Date

This form MUST be submitted by the application deadline to the licensing program for which the applicant is applying:

**Division of Occupational Licensing
P.O. Box 110806
Juneau, Alaska 99811-0806.**